82 Final Prospective Rate. Upon final audit of a all nursing facility's base year cost reports, the Department will determine a final prospective rate. The final prospective rate will be used as the basis for determining any adjustment that is required to adjust the computation of the median for the indirect cost and routine cost components for the 1993 fiscal year.

82.1 Adjustments to the Median Base Year and Upper Limit Computation for the Indirect and Routine Cost Components. The Department of Human Services in computing the base year median and upper limits for the routine and indirect cost components will rely on the most recent available data from the automated cost report data file. To the extent that the data on this file is unaudited data, the computation will be recomputed when base year audits on all nursing facilities have been completed to determine the variance between the initial computations and the audited data computations. If the variance is material (+ or - 1%) the rates in the 1993 fiscal year will be adjusted to reflect the audited data.

83 Second and Subsequent Years: Interim Prospective Rate. At least fifteen days prior to the commencement of a facility's second fiscal year in the prospective system, the Department will assign it an interim prospective rate which will apply for services rendered on or after the first day of that fiscal year.

The interim prospective rate in the second and subsequent years is the sum of 1) the fixed cost component of the final prospective rate in the base year, 2) the direct cost component rate, 3) the indirect cost component rate , and 4) the routine cost component rate of the base year final prospective rate, and 5) an inflation adjustment. The inflation adjustment is the forecasted increase in the cost of goods and services as determined in accordance with Section 91 multiplied by the direct, indirect and routine cost components rates of the first year final prospective rate.

The interim prospective rate in the third and subsequent fiscal years will be determined in the same manner as outlined in the second year.

84 Final Audit of First and Subsequent Prospective Years.

84.1 Principle. All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms provided by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:

84.2.1 determine the actual allowable fixed costs incurred by the facility in the prior fiscal year,

84.2.2 determine the amount of an incentive payment (computed in Subsection 86.3), if any, which a facility has earned,

84.2.3 calculate a final rate, and

84.2.4 calculate any adjustments necessary to the current prospective rates for all nursing facility's based on the above determination.

85 **Settlement of Fixed Expenses**

85.1 The Department will reimburse facilities for the actual allowable fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of the final prospective rate multiplied by the number of days of care provided to Medicaid beneficiaries), the difference will be paid to the facility by the Department. If, the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs which a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.

The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform Act of 1987 will be considered in the appropirate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount

paid by the Department, the difference will be paid to the Department by the facility.

86 Establishment of Peer Group and Incentive Payments

86.1 Establishment of Peer Group. All Nursing care facilities will be included in one of two peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one peer group, all other nursing facilities will be included in the second peer group. Please refer to Appendix C for a description of a hospital based nursing facility. It should be noted that the establishment of these two peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate medicare upper limit test will be applied to all nursing facilities.

86.2 The relationship between each facility's direct, indirect and routine allowable cost per day as determined in Section 80 of these Principles and those of its peers will be determined once a year. The peer groups will form the basis for determining the median indirect and routine costs. The peer groups will be subject to the same upper limits. Nursing facilities in the lowest quartile in the routine cost component will receive an incentive payment as described in Subsection 86.3.

86.3 Incentive Payments. All nursing facilities will be divided into four quartiles according to their per diem routine cost per day (as determined in Section 43.

Facilities in the bottom quartile for the routine cost per patient day will be entitled to receive an additional $1.00 per diem incentive payment included in their prospective rate. This computation will be completed each year to determine the facilities that are in the lowest quartile. Facilities that remain in the bottom quartile will continue to receive the additional $1.00 per diem as an incentive payment. Facilities that fail to keep their routine cost component in the lowest quartile in succeeding years will cease receiving the $1.00 per diem incentive payment.

86.4 Conditions for Incentive Payment. A facility which is seriously deficient in the maintenance of its physical plant or the care provided to residents will not be entitled to receive an incentive payment. The issuance of a conditional or temporary license or the reduction of a facility's payments for failure to correct its deficiencies will render a facility ineligible to receive an incentive payment. In such cases, the Department will

recover the full amount of any difference between the Department's appropriate share of its allowable operating expenses and the amount paid by the Department.

87 **Second and Subsequent Year Final Prospective Rate.** Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

The final lump sum amounts either due to or from the nursing facility in the second and subsequent years is the difference between the prospective rate and the sum of (1) actual fixed costs, direct patient care costs, indirect patient care costs, routine care costs, and (2) audited base year rates for indirect patient care and routine patient care adjusted to the current fiscal year by the appropriate inflationary factor subject to the upper limit as established by the federal government and (3) the lesser of actual or approved direct patient care costs.

88 **Calculation of Overpayments or Underpayments.** Upon determination of the final rate in the second year as outlined in Section 87 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will estimate the amount due and forward the result to the facility within thirty days. If the Department determines that has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning 60 days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 150.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year, 2) the amount of savings, if any, earned by a facility and 3) the estimated difference in amount due or paid based on the interim versus final prospective rate.

90 Hold Harmless

No nursing facility shall receive a rate lower than 95% of that facility's base year allowable cost as established in Section 80 of these Principles inflated to the current year beginning on October 1, 1992. The facility's rate in the fiscal year beginning October 1, 1993 will not be lower than 90% of that facility's base year allowable cost as established in Section 80 of these Principles inflated to the proper fiscal year.

The hold harmless computation is based on the allowable cost of the nursing facilities base year. Once the base year allowable cost has been identified for each of the four cost components (direct patient care, indirect patient care, routine patient care and the fixed cost component) the allowable costs are inflated to the period ending September 30, 1992. The inflated base year allowable costs for all cost components is multiplied times .95% for the implementation year that begins October 1, 1992. This determines the lowest allowable cost (rate) that will be recognized for the nursing facility on October 1, 1992. This same methodology will be applied to the facilities subsequent fiscal year with the difference being the multiplier will be .90%.

91 Inflation Adjustment

91.1 The Maine Health Care Facility Economic Trend Factor will be used to forecast the expected increases in the wages and salaries for nursing care facilities.

The cost components, weights, proxies and method by which the Maine Health Care Facility Economic Trend Factor will be calculated are as follows:

91.1.1 **Cost components:** 1) wages and salaries, 2) employee benefits, 3) food, 4) fuel and other utilities, and 5) other expenses.

91.1.2 **Cost component weights:** The Department will use the most recent Nursing Facility Weights as published by Data Resources, Inc., of Washington, D.C.

91.1.3 **Cost compensation proxy:** The Department will use the most recent Nursing Facility %MOVAVG, published by Data Resources, Inc., of Washington, D.C., for all cost components except for employee wages and salaries.

The proxy for wages and salaries to be used in the Maine Health Care Facility Economic Trend Factor which will be calculated by the Department. The proxy for wages and salaries will equal the sum of the Maine specific

weights for professional and technical workers and service workers times the cost compensation proxies used by the Maine Health Care Finance Commission for the same category of workers. The relative weights will be calculated every three years by the Department based on a study of the relative total costs of these categories of workers in all Maine nursing homes for the most recent available year.

91.1.4 **The Maine Health Care Facility Economic Trend Factor** is equal to the sum of the product of a) the cost component weight, and b) the cost compensation proxy component.

The Division of Audit shall use the most recent available projections of the applicable compensation cost proxies as published by Data Resources, Inc., for the Maine Health Care Finance Commission.

92 **Regions.** The regions shall be the regions defined by the Maine Health Care Finance Commission for hospitals. The regions are:

Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.

Region II - Androscoggin County, Franklin County, Kennebec Count y, Oxford County, and Somerset County.

Region III - Penobscot County, Piscataquis County, Waldo Count y, Hancock County and Washington County.

Region IV - Aroostook County

100 Changes in Staffing

100.1 **Nursing and Non-Nursing Personnel Wages, Salaries and Benefits.** The base year costs for nursing and non-nursing personnel wages, salaries and benefits, shall be the lower of actual or approved staffing costs incurred by the facility in facilities fiscal year which began in 1990.

The Department will not include any expenditures related to employee wages, salaries and benefits for hours in excess of those hours approved by the Division of Licensure and Certification in the calculation of each facility's base year. Refer to Principle 100.2 for costs associated with additional hours being added subsequent to its fiscal year which began in facility fiscal year 1990.

100.2 **Nursing Personnel/ Approved Staffing.** In the event that a facility believes that by requesting incremental payments for new Level IV and V residents from the base year and, consequently,

that an increase or decrease in the number of full-time equivalent nurses and nurses aides it employs is warranted, it may request the Department to conduct an audit of its residents and their needs.

The facility must request in writing for approval of additional nursing staff prior to the facility hiring any new staff. Any increase in staff that is not prior approved by the Division of Licensing and Certification will not be considered an allowable cost. The Department will not approve additional nursing staff for any period prior to the first (1st) month following receipt of the written request.

The cost associated with any direct patient care hours added as a result of new level IV and V residents by a facility subsequent to its fiscal year beginning in 1990 will be made available by the Department in the form of a incremental payment as stipulated in Section 45 of these Principles. After the full fiscal year, the cost associated with these additional hours will be added to the facility's final prospective rate at the time the Department determines its prospective rate for the coming year. Such additional hours, when added to the hours used for the rebasing calculation, may not exceed the facility's approved staffing pattern.

The cost associated with direct patient care personnel hired subsequent to the base year, which remain below the approved staffing level for the facility as established by the Division of Licensing and Certification will be incorporated into the facility's interim rate when the position has been filled. The facility must notify the Division of Audit when the approved position has been filled and provide the Division of Audit with the employee's name, social security number, date of hire and rate of pay.

The facility will be responsible for maintaining appropriate records which the Department can audit to demonstrate the need for changes in staffing (either increases or decreases) based on the needs and changes in needs of its residents.

If the Department determines that the needs of the residents are not adequately met, it may order the facility to retain the additional personnel needed to do so.

When the Division of Audit identifies a direct patient care cost savings which is attributed to a facility staffing below what is built into the facility's direct patient care cost component, the Division of Audit will notify the Division of Licensure and Certification. The Division of Licensure and Certification will then conduct a determination of levels of care which may result in a review and revision of the facility's approved staffing pattern.

Facilities will no longer be held to a set staffing pattern. Facilities must meet the staff requirements set forth by the Division of Licensing and Certification. However, the nursing facility is responsible for establishing its own patterns of staffing in the direct patient care cost component.

100.3 **Non-nursing Personnel.**

If the Department has reason to believe that a facility has a number of full-time equivalent non-nursing personnel in its employ which is less than the number needed to adequately serve its residents, the Department may authorize the facility to retain additional personnel needed to do so.

The cost associated with Non-nursing personnel hired subsequent to the base year, which remain below the approved staffing level for the facility as established by the Division of Licensing and Certification will be incorporated into the facility's interim rate when the position has been filled. The facility must notify the Division of Audit when the approved position has been filled and provide the Division of Audit with the employee's name, social security number, date of hire and rate of pay.

110 **Transfer of Ownership.** In the case of a sale of a facility, the Department will review the new owner's Certificate of Need application and evaluate the appropriateness and reasonableness of the capital related costs as well as operating costs as set forth in Section 81.

In the case of a sale of a facility, costs determined through the certificate of need review process must be approved by the Bureau of Medical Services. Prior approval of all requested staffing changes must also be obtained from the Bureau of Medical Services.

The Department will establish a prospective rate for the new owner of the facility based Section 80.6 in these Principles and, on its analysis under the Certificate of Need process.

120 **Extraordinary Circumstance Allowance.** Facilities which experience unforeseen and uncontrollable events during a year which result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

* events of a catastrophic nature (fire, flood, etc.)
* unforeseen increase in minimum wage , Social Security, or employee retirement contribution expenses in lieu of social security expenses
* changes in the number of licensed beds
* changes in licensure or accreditation requirements

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

130 ADJUSTMENTS

130.1 **Adjustment for Unrestricted Grants or Gifts.** Unrestricted Federal or State grants or gifts received by a facility and which have been deducted from operating costs for purposes of reimbursement will be added back to the direct patient care, indirect patient care and routine cost component for purposes of calculating a base rate.

130.2 **Adjustment for Appeal Decisions.** The Department will adjust any interim or final prospective rate to reflect appeal decisions made subsequent to the establishment of those rates.

130.3 **Adjustments for Capital Costs.** Upon request the Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases in capital costs which have been approved under Section 1122 of the Social Security Act or the Maine Certificate of Need Act.

140 Appeal Procedures - Start Up Costs - Deficiency Rate -Rate Limitation

140.1 Appeal Procedures

140.1.1 A facility may administratively appeal any of the following types of Division of Audit determinations:

1. Audit Adjustment
2. Calculation of final prospective rate
3. Adjustment of final prospective rate or a refusal to make such an adjustment pursuant to these Principles.

140.1.2 An administrative appeal will proceed in the following manner:

1. Within 30 days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and time

frame will be considered at an informal review or at a subsequent administrative hearing.

2. The Director or his/her designee shall notify the facility in writing of the decision made a a result of such informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designed to the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.

3. To the extent the Department rules in favor of the facility, the audit report or prospective rate will be corrected.

4. To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

50 Start Up Costs Applicability. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first patient is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.